EXHIBIT 1620-9

ALTCS ENROLLMENT TRANSITION INFORMATION FORM (ETI)

ALTCS ENROLLMENT TRANSITION INFORMATION (ETI) FORM

Sending PC: _____ **Receiving PC:** _____

Transition Date: _____ **Rate Code:** _____

Member Name: _____ **DOB:** _____

AHCCCS ID: _____ **M or F (circle one)**

Primary Language Spoken: _____

Contact Person / Relationship:
indicate if Guardian, POA, etc _____

Contact Person Phone #: _____

PRIMARY HEALTH INSURANCE

Medicare #: _____ **Part A B D (circle all that apply)**

Medicare Advantage -PDP: _____ **SNP?** ☐ YES ☐ NO

PDP: _____ **Other:** _____

MEMBER LOCATION

Current Address: _____

Phone Number: _____

Facility Name (if applicable): _____

Type of Facility: ☐ **Skilled Nursing Facility** ☐ **Assisted Living Facility** ☐ **Behavioral Health**

Admission Date: _____ **Specialty Unit:** _____

Level of Care: _____ **ALF Room and Board Amount:** _____

MEDICAL INFORMATION

Diagnoses: _____

PCP Name: _____ **PCP Phone** #: _____

Specialists (Including out of area)

Name: _____ **Type:** _____ **Phone #:** _____

Name: _____ **Type:** _____ **Phone #:** _____

Scheduled appointments/procedures: _____

Special Medications/Treatments: _____

CRS Services: _____

Pending Physicians orders not yet completed: _____

Revised 07/01/2008, 10/01/2007, 12/01/2006

Member Name: _____

DIALYSIS

Site Name and Address: _____

Days: M T W Th F Sat Sun **Phone Number:** _____
Time: _____

Transportation Provided by: _____

Assistance and/or Type of Transportation Required: _____

_____

DME/SUPPLIES (see attached information for additional details on DME/Supplies as needed)

DME: _____ ☐ **Rented?** ☐ **Owned?** **Provider:** _____

DME: _____ ☐ **Rented?** ☐ **Owned?** **Provider:** _____

DME: _____ ☐ **Rented?** ☐ **Owned?** **Provider:** _____

DME: _____ ☐ **Rented?** ☐ **Owned?** **Provider:** _____

Supplies Needed: _____ **Provider:** _____

Supplies Needed: _____ **Provider:** _____

Supplies Needed: _____ **Provider:** _____

Pending Issues requiring follow-up: _____

_____

PENDING GRIEVANCE? **Yes** **No** **Expected Resolution Date:** _____

What is nature of grievance? _____

HOSPITALIZED MEMBERS (complete if member is hospitalized on date form is completed)

Hospital: _____ **Phone:** _____

Admission Date: _____ **Admitting Diagnosis:** _____

Inpatient Treatments: _____

Expected Discharge Date: _____ **D/C To:** _____

OTHER/COMMENTS: _____

_____

_____

_____

Revised 07/01/2008, 10/01/2007, 12/01/2006

ALTCS ETI Form, Page Three

Member Name: _____

HCBS SERVICES (Check all that apply or attach Service Authorizations for details)

☐ **Adult Day Health**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Attendant Care**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Home Delivered Meals**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Homemaker**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Personal Care**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Respite**	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Other** _____	**Provider:**		**Phone#:**		**Frequency:**	
☐ **Emergency Alert**	**Provider**		**Phone#:**			

☐ **Home Health Nursing**

Provider: _____
Phone#: _____ **Frequency:** _____
Payer Source: _____

☐ **Home Health Aide**

Provider: _____
Phone#: _____ **Frequency:** _____
Payer Source _____

☐ **Hospice**

Provider: _____
Phone#: _____ **Frequency:** _____
Payer Source: _____

Revised 07/01/2008, 10/01/2007, 12/01/2006

Member Name: _____

BEHAVIORAL HEALTH

BH Diagnosis: _____

BH Medications: _____

BH Services/Providers:

Service	Provider	Phone #	Frequency

# of Inpatient days remaining: _____ **Last Date of Judicial Review:** _____ **Outcome:** _____

☐ **COT** **Name on Court Order:** _____ **Expiration Date:** _____

REQUIRED ATTACHMENTS AND OTHER TRANSITIONING INFORMATION:

☐ Last CM Assessment

☐ CM Summary

☐ Last Quarterly Behavioral Health Consult, if applicable

☐ Advanced Directives (Living wills, Powers of Attorney, etc), if applicable

☐ List of Medications

☐ EPSDT Forms, if applicable

☐ Contingency Plan, if member receiving critical services

☐ Guardian/Conservatorship or Power of Attorney, if applicable

Case Manager Name: _____ **Phone:** _____ **Date:** _____

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